Objective 9.18: Provide academic instruction on injury prevention and control, preferably as part of quality school health education, in at least 50 percent of public school systems (grades K through 12).

Injury Prevention Instruction in Schools	Baseline	2000 Target
Public school systems	66.2%	50%

Barriers:

Schools are facing economic difficulties, especially in urban areas; teachers are frequently overextended by professional demands.

Neither schools nor the public perceive unintentional injury prevention as a major health issue that should be included in the curriculum, given limited funding and classroom time.

Competition for use of teaching modules covering other health topics.

Information on effective injury prevention education is lacking; without this information it is difficult to convince schools that injury prevention education is a worthwhile expenditure of their efforts.

Strategies:

Promote comprehensive school health education programs to address major health issues, including injury prevention and control.

Coordinate injury intervention programs in schools (i.e.: Fire Prevention week, driver education programs, alcohol and other drug education programs).

Develop guidelines for school programs to prevent unintentional injuries and violence.

Conduct research to demonstrate efficacy and feasibility of school-based injury prevention programs.

Data Source: National Center for Chronic Disease Prevention and Health Promotion, CDC

Objective 9.19: Extend requirement of the use of effective head, face, eye, and mouth protection to all organizations, agencies, and institutions sponsoring sporting and recreation activities that pose risks of injury.

Require Use of Protective Gear During Sporting and Recreation Activities	1988 Baseline	1991	2000 Target
National Collegiate Athletic Association			All sponsored sports events
Football	Required		
Hockey	Required		
Lacrosse	Required		
High School football	Required		
Amateur Boxing	Required		
Amateur Ice Hockey	Required		
Use of protective headgear and mouth guards among children who play sports:			
Baseball/softball			
Headgear		35%	
Mouth guard		7%	
Football			
Headgear		72%	
Mouth guard		72%	
Soccer			
Headgear		4%	
Mouth guard		7%	

Objective 9.19: Extend requirement of the use of effective head, face, eye, and mouth protection to all organizations, agencies, and institutions sponsoring sporting and recreation activities that pose risks of injury.

Barriers:

Concern that protective gear may hamper "play"; conflicts with "macho attitudes".

Existing myths and attitudes about the risk of injury and the interference of protective gear.

Precedent of non-use prior to the development of proven safety devices fosters the notion that this is the way to "play".

Cost of protective equipment may be prohibitive to individuals and/or sports organizations.

Strategies:

Poll major sports and recreation organizations to determine the existence of policy regarding the use of protective gear.

Encourage sports groups to be consistent in requirement of safety gear.

Data Source: *Academy of Sports Dentistry*

Additional Data Sources: *National Health Interview Survey, NCHS, CDC*
Youth Risk Behavior Survey, NCCDPHP, CDC

Objective 9.20: Increase to 50 the number of states that have design standard for markings, lighting, and other characteristics of the roadway environment to improve the visual stimuli and protect the safety of older drivers and pedestrians.

States with Design Standards for Roadway Safety	Baseline	1998	2000 Target
	Baseline available in 1997	50	50

The Federal Highway Administration produced and disseminated the *Older Driver Highway Design Handbook,* publication *no. FHWA-RD-97-135, in January 1998.*

Data Source: *Federal Highway Administration, Department of Transportation*

Objective 9.21 Increase to at least 50 percent the proportion of primary care providers who routinely provide age-appropriate counseling on safety precautions to prevent unintentional injury.

Injury Prevention Counseling	1992 Baseline		1997	2000 Target
Primary care providers	---			50%
Percent of clinicians routinely providing service to 81-100% of patients				
Inquiry about seat belt/child care seat use				
Pediatricians	45%			50%
Nurse Practitioners	29%			50%
Obstetrician/Gynecologists	6%			50%
Internists	11%			50%
Family Physicians	16%			50%
Inquiry about hazards for falls in the home (ages 65 and older)				
Nurse Practitioners	15%			50%
Internists	10%			50%
Family Physicians	7%			50%
Advice about seat belt/child care seat use				
Pediatricians	58%			50%
Nurse Practitioners	32%			50%
Obstetricians/Gynecologists	18%			50%
Internists	15%			50%
Family Physicians	29%			50%
Advice about prevention of falls in the home (ages 65+)				
Nurse Practitioners	17%			50%
Internists	17%			50%
Family Physicians	15%			50%

Objective 9.21 Increase to at least 50 percent the proportion of primary care providers who routinely provide age-appropriate counseling on safety precautions to prevent unintentional injury.

Note: Response rates to the Primary Care Providers Survey were: Family Physicians 50%, Pediatricians 58%, Nurse Practitioners 70%, Obstetrician/Gynecologists 71% and Internists 80%. Data on assessment/injury represent the proportion of providers who queried 81-100% of their patients. Data on counseling/treatment/referral represent the proportion of providers who delivered these services to 81-100% of their clients who need the particular intervention.

Barriers:

Conflicting recommendations and/or too many topics to discuss (e.g., traffic crashes, fire & burn prevention, drowning, poisoning, choking, falls).

Lack of research data to prove the effectiveness of physician counseling on injury prevention topics.

Counseling by primary care providers is not a reimbursable health care item.

Competing demands for curative medicine/screening/immunization, and ambulatory complaints leave little or no time for counseling.

Injury prevention is not emphasized as a public health concern during medical school training.

Strategies:

Work with professional associations of health care providers (e.g., physicians, physicians assistants, nurse practitioners) to encourage clinical preventive services including counseling.

Promote integration of injury control information in education (undergraduate, medical residency, Schools of Public Health, and continuing-education curricula).

Conduct research to demonstrate the effectiveness of injury prevention counseling.

Seek funding for prevention counseling (private and public sector insurance industry).

Increase patient demand for injury prevention counseling through media influence.

Target counseling for high-risk groups (e.g., children and the elderly).

Data Source: *Office of Disease Prevention and Health Promotion, OASH*

Objective 9.23: Reduce deaths caused by alcohol-related motor vehicle crashes to no more than 5.5 per 100,000 people.

Alcohol-Related Motor Vehicle Crash Deaths	1987 Baseline	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	2000 Target
Total Population	9.8	9.7	9.1	8.9	7.9	7.0	6.8	6.4	6.6	6.5	6.1	5.5
Special Population Targets												
23.1a American Indian/Alaskan Native men	40.4	35.6	32.9	34.3	32.2	31.4	26.8	28.0	---	---	---	35.5
23.1b People aged 15-24	20.9	21.3	18.7	18.6	17.2	14.2	13.7	13.0	12.9	12.8	11.7	12.5

Barriers:

Inadequate sanctions to discourage drinking and driving and lack of access to alcohol treatment programs for chronic DWI offenders.

Encourage states to adopt administrative license revocation and 0.08 BAC limit; encourage sobriety checkpoints as a deterrent for impaired drivers; and support alcohol treatment programs

American Indians
Lack of quantitative data (such as BAC) on alcohol involvement in crashes. Lack of Deterrence--Indian tribes have their own law enforcement and court systems which in some cases cannot instill the same level of deterrence as law enforcement in non-Indian communities. For example, most Indian tribal police cannot suspend or revoke a state driver's license for DWI on Indian lands. Lack of occupant restraint use. Many American Indians live in Rural areas and have risk factors mentioned in 9.1

People age 15-24
Lack of routine screening.
Perception by some that teen drinking is the "norm", and not a big problem. Lack of graduated licensing laws and curfew laws for teens to reduce exposure to nighttime driving. Lack of wide spread sobriety checkpoint programs, not all states have administrative license revocations laws for DWI.

Lack of routine comprehensive screening and treatment for DWI offenders.

Lack of knowledge about drinking and driving laws and about alcohol's effects on driving skills (all drivers).

Strategies:

Encourage States and Indian tribes to adopt administrative license revocation laws; promote adoption of 0.08 blood alcohol content (BAC) laws for drivers over age 21, and comprehensive alcohol screening and treatment for DWI offenders.

Encourage states to implement effective graduated licensing systems.

Encourage enforcement of zero tolerance laws for drivers under age of 21 years.

Encourage communities to strictly enforce laws limiting access of alcohol to youth and young adults under age 21.

Encourage sobriety checkpoints as a deterrent for impaired driving; support alcohol and drug treatment programs.

Support evaluation of effectiveness of community-based programs aimed at reducing drinking and driving.

Increase public awareness of alcohol-driving laws.

Increase public understanding of the effect of alcohol on driving-related skills, including impairment at consumption levels below the legal limit.

Data Source: *FARS, NHTSA; IHS*

Objective 9.26: Increase to 35 the number of states having a graduated driver licensing system (GDLS) for novice drivers and riders under the age of 18.

	1993 Baseline		1994	1997	2000 Target
Number of States	---		0	11	35

Barriers: Policy is often misunderstood-public thinks it raises the driving age. Public is not well informed about the magnitude of the teenage traffic fatality/injury problem. Policy is difficult to enforce.

Strategies: Educate the public; especially parents and teenagers, about the rise of motor vehicle crashes to teens.

Educate the public; especially parents and teenagers, about the components of graduated licensing systems.

Evaluate components of graduated licensing systems.

Encourage states to implement graduated licensing systems.

Encourage parents to implement the concept of graduated licensing in their own family.

Data Source; *Insurance Institute for Highway Safety*